

## GATEWAY HEALTH PLAN® DRUG EXCEPTION FORM

Please use this form to request coverage of a nonformulary drug or quantity limit exception for an **individual** patient. This form may be copied for office use. To request coverage of a drug that requires a prior authorization or step therapy, please use the drug specific prior authorization or step therapy form available on the website at [www.gatewayhealthplan.com](http://www.gatewayhealthplan.com).

Complete all of the information requested and **FAX THE FORM TO (888) 245-2049**.

- Gateway will contact the MD if additional clinical information is needed.
- If the request is denied, the MD can change the prescription to an appropriate formulary alternative or with member written consent file an appeal with Gateway.

Member ID#: _____	
Member Name: _____	Date of Birth: _____
Pharmacy Name: _____	Pharmacy Phone: _____

DRUG NAME: _____																				
DOSAGE/FREQUENCY: _____																				
DIAGNOSIS FOR WHICH ABOVE DRUG IS PRESCRIBED: _____																				
_____																				
You must be able to document the ineffectiveness of formulary alternatives or the reasonable expectation of adverse reactions from the use of formulary products for a request to be approved. Please document formulary alternatives previously used and the clinical rationale for the requested drug in the space below. Additional pages of clinical information, such as laboratory results, may be faxed with this form.																				
<b>FORMULARY ALTERNATIVES THAT HAVE BEEN USED BY THE PATIENT</b>																				
<table style="width: 100%; border-collapse: collapse;"><thead><tr><th style="text-align: left;"><u>Drug Name</u></th><th style="text-align: left;"><u>Strength</u></th><th style="text-align: left;"><u>Dates Used</u></th><th style="text-align: left;"><u>Documentation of failure of therapy</u></th></tr></thead><tbody><tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr></tbody></table>	<u>Drug Name</u>	<u>Strength</u>	<u>Dates Used</u>	<u>Documentation of failure of therapy</u>	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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<u>Additional Clinical Information:</u>																				
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PHYSICIAN NAME (Printed): _____	PHONE: _____
PHYSICIAN SIGNATURE: _____	DATE: _____